Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

<u>Emailed</u> Questions and Answers
Regarding the New and Modified Service Definitions

March 15, 2006

Number	Service Definition Component	Question	Response
1	ACTT	Staffing requirements and staff to consumer are confusing and vary depending on whether it is a large or small team. Please clarify what criteria will be used for conditional endorsement.	The minimum staff to consumer ratio for conditional endorsement must not be less than 1 staff per 10 consumers. Every team should be able to serve at least 50 consumers. The following staff are the minimum requirements to meet this ratio: 1 master's level qualified mental health profession who is the team leader ; 1 registered nurse who is a qualified mental health professional; 2 qualified professionals with preference for 1 being a masters level qualified mental health professional and 1 being a qualified substance abuse professional with at least Certified Substance Abuse Counselor (CSAC); and 1 additional staff who may be a master's or bachelor's level QMHP. In addition to the staff listed above, 16 hours per week of psychiatrist time for every 50 individuals served and a program assistant are required, but do not count toward meeting the 1 staff to 10 consumer requirement. Note that a "certified" peer support specialist will not be required until a certification process has been published and made available by DMH/DD/SAS. Teams that are serving more than 50 people and/or as teams add staff to expand the number of consumers served, providers should be able to document that the staff composition is consistent with staffing requirements and 1 to 10 ratio listed in the ACTT service definition to achieve full endorsement

Number	Service Definition Component	Question	Response
2	ACTT	May a licensed clinical social worker (LCSW) who was licensed under the Social Work Certification Board requirements be considered equivalent with having a master's degree?	If a licensed clinical social worker (LCSW) who received this credential under the now expired "grandfathering" provision for licensure has been recognized by Medicare (i.e. has a Medicare provider number), the LCSW will be accepted by Medicaid as being equivalent to an LCSW with a master's degree.
3	ACTT	What training is required and when must it be completed?	The training requirement is that each ACTT team staff member must complete DMH/DD/SAS approved training but does not specify any specific number of hours of training. Currently approved ACTT training is available from the North Carolina Evidence Based Practice Center. http://www.ncebpcenter.org/brochures.htm During this transition period, training must be completed within 18 months from the date of Medicaid enrollment and is required in order to receive full endorsement.
4	ACTT	The rate schedule indicates that ACTT (H0040) is to be billed as an "event" with a maximum of 4 per month. Is this consistent with the program requirements regarding amount of contact expected with consumers?	ACTT is a "team" service that is billed for 4 "events" per month. An "event" can not be billed unless there has been a face to face contact with the consumer during the week. Services provided by the team can not be billed by individual staff. The rate for an "event" is based on having the required staff who are expected to provide the intensity of service that is needed by each individual served by the team. Service expectations are based on aggregate team data that the team will have an average of three contacts per week with each consumer. Decisions about how frequently a consumer is seen must be based on the individual consumer's needs and Person Centered Plan.
5	Clinical Home	What are the guidelines for the determination of the Clinical Home?	The clinical home is considered the service best able to provide continuity of care for a consumer in the system. In most instances the clinical home will be the Community Support provider who has been identified. One of the roles of Community Support is

Number	Service Definition Component	Question	Response
			developed to provide support to the consumer and family throughout the range of services. However, if a person initially requires a comprehensive service, such as Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, or Assertive Community Treatment Team, the clinical home may be the case management component of the comprehensive service. Ultimately, when a person only requires less intensive services, the transition to Community Support occurs. The clinical home will transition to the Community Support provider at this point.
6	Community Support	Is each consumer in the target population required to have Community Support? Please clarify the ratios in instances of many consumers receiving the minimum Community Support (2hrs/month).	For Medicaid-eligible consumers, Community Support is a basic service designed to support all target population consumers in achieving recovery. If a consumer meets target population definitions, it is expected that Community Support will be a component of their Person Centered Plan to assist in the development, implementation, monitoring, and delivery of services as necessary to achieve maximum recovery. In recognition of the ratio limitations, there has been added the ability to serve additional consumers who are receiving the minimum Community Support without those consumers counting in the ratio. Those changes for children are 10 additional consumers may be served with minimal Community Support authorized (2 hrs/month, maintaining the 1:15 ratio) and for adults 15 additional consumers may be served with minimal CS authorized (2hrs/month, maintaining the 1:30 ratio). Please see communication bulletin #6. NOTE: These ratios do not apply to outpatient therapists.
7	Community Support	Can Associate Professionals do Qualified Professionals' work in Community Support? There are currently many Associate Professionals doing	The definition of Community Support clearly indicates that a Qualified Professional must be in charge of developing the Person Centered Plan, and monitoring the services provided therein. It is not possible for an Associate Professional to perform those Qualified Professional functions under the definition. A Qualified Professional may perform any services of an AP. It is expected

Number	Service Definition Component	Question	Response
		case management under supervision. What about a possible child/adult mix of cases? Ratios?	that the level of professional service/interventions will be raised with Community Support, including the skill building capacity of Community Support working with consumers. Both children and adults may be served by the same Community Support provider, understanding the Community Support meets the requirements for "experience with the population served" for all populations served. The ratio will be determined by the case mix and should be adjusted to address both level of acuity of case load, and population served. This adjustment should be documented to demonstrate clinical decision making for the ratio served.
8	Community Support	Please clarify the initial 30 day authorization for Qualified Professional and Diagnostic Assessment under Medicaid.	For Medicaid-eligible consumers, the initial authorization of Community Support is to quickly provide support for consumers while additional needs are assessed. The amount of Qualified Professional service available must be within the limitations of the definition or additional authorization must be sought. However, if a consumer is using a maximum of Qualified Professional in the first 30 days while the Diagnostic Assessment is being completed, it may be appropriate to seek a higher level of intervention beyond Qualified Professional. Documentation should indicate the services provided for the consumer based on indicated need as determined by the provider. These Qualified Professional services paid during the period will be subject to post payment review to assure the appropriateness of the service provision. Reauthorization of Qualified Professional must occur at least every 90 days.
9	Community Support	Can an agency subcontract for case management or Community Based Services (CBS) to provide Community Support?	Community Support is a service that combines aspects of case management, first responder, skill building, etc for consumers and families. It is not merely a "combination" of CBS/Case Management. However, in the endorsement of a provider to provide Community Support, the provider endorsed may have subcontracts for services that allow for the provision of the Community Support

Number	Service Definition Component	Question	Response
			service with the permission of the Local Management Entity per the Memorandum Of Agreement. It is the expectation that the endorsed agency has full responsibility for the cases served in that endorsed service.
10	Community Support	Can Community Support be provided to consumers in alternative treatment settings ie: day treatment and residential settings? Can alternative treatment settings also bill for Community Support?	Community Support may be provided for up to 8 units per month while a child or adolescent is in an alternative setting. Under the new definitions many of the case management functions have been located within the specific service. The Community Support provider who is providing continuity oversight for the consumer and the family may bill for up to 8 units per month. There is no Community Support billed by residential services, day treatment, etc as those services are incorporated within the rate for the service provided.
11	Community Support (group)	How are Community Support groups billed? Are groups counted as a full unit?	Community Support group may contain a maximum of 8 consumers per group and may be billed the group rate that has been set (please see established rates per Division of Medical Assistance). These rates are established per 15 minute units, per person in the group.
12	Endorsement	One company has received a conditional endorsement for only 6 months at one Local Management Entity while others offer an 18-month. Given that we will have 1 year to complete the staff training, should all endorsements be 18 months?	The Division of MH/DD/SAS and the Division of Medical Assistance have agreed that during the transition provider enrollments (in Medicaid) will be for 18 months. It is understood that some early endorsements were for shorter periods of time but the current practice is as stated above.
13	Endorsement	One Local Management Entity is requiring a signed Memorandum Of Agreement between	The Local Management Entity cannot add requirements to the application or check sheets. The provider should contact Dick.Oliver@ncmail.net with the name of the Local Management Entity and the specific

Number	Service Definition Component	Question	Response
		the provider and a psychiatrist in order to be endorsed while the application only asks us to identify the psychiatrist with whom they have consulting arrangements. Can this be clarified?	requirement. Division staff will investigate the complaint within 4 business days.
14	Endorsement	Has the Division suggested a time period for the "ramp-up" of provider services? Some Local Management Entities are demanding that all staff be in place for all services prior to endorsement. This is very difficult to accomplish without a revenue stream. It is also not prudent for companies to make any startup investment when they know that the LME is favoring or financially supporting a spin off agency or indicating that they plan to get back into services.	The Local Management Entity cannot add requirements to the application or check sheets. The check sheets do not require the provider to have staff employed at the time of conditional endorsement. However, the service cannot be provided without qualified staff. The provider should contact Dick.Oliver@ncmail.net with the name of the Local Management Entity and the specific requirement. Division staff will investigate the complaint within 4 business days.
15	Endorsement	Some Local Management Entities are requiring for endorsement the name of the psychiatrist on our Diagnostic Assessment team – I think they have this requirement on their checklist. Since	The Local Management Entity cannot add requirements to the application or check sheets. The provider should contact Dick.Oliver@ncmail.net with the name of the Local Management Entity and the specific requirement. Division staff will investigate the complaint within 4 business days.

Number	Service Definition Component	Question	Response
		this is neither in the service definitions nor the Core Rules Self Study, can this be required?	
16	Endorsement	The current checklist for Phase III of Endorsement includes a check sheet for Outpatient Opioid Treatment Program and Bulletin 53 indicates that Methadone Administration is to be Endorsed during Phase III. The problem with this is the fact that no new service definition exists to implement or that indicates the service must be Endorsed. Am I looking at it wrong and just overlooked something. Any assistance you provide, as soon as possible, would be greatly appreciated since I am currently holding a request for Endorsement of this service from a local Provider.	There is a definition in Service Definition Manual, dated January 2003. Endorsement is a quality assurance and verification process involving providers of mh/dd/sa services. Providers of all enhanced benefit services in Phase III are required to go through endorsement.
17	Endorsement	It has been noted that all enhanced definitions go into effect on 3/20/06, however on the question and answers sheet dated 2/24/06, item 64 states the provider's responsibilities begins when they	The providers' responsibilities begin when they begin providing the service after the 3/20/06 implementation date. This is a clarification of the statements made in the document dated 2/24/06.

Number	Service Definition Component	Question	Response
		become endorsed. Please clarify if the provider is required to comply with the new definition on 3/20/06 or when they become endorsed?	
18	First Responder	Does the person who is carrying out First Responder responsibilities need to be part of the provider agency staff?	Providers who have a "First Responder" requirement must have policies and capacity in place to "respond in a clinically appropriate way to their consumers on a face-to-face basis and also telephonically at all times (24/7/365), with capacity for face-to-face emergency response within 2 hours". It is expected that in order to provide adequate service as a first responder, the responder must have knowledge of the consumer's PCP and crisis plan.
19	First Responder	What needs to happen during regular work hours?	First responder capacity and requirements are designed to be responsive to consumers in a variety of ways including both telephonic and face-to-face capacity. During regular business hours, it is expected that provider agency staff person who is most familiar with the consumer and the consumer's PCP including a crisis plan with information about proactive, reactive, and crisis contingencies. Response is to be consistent with the actions that have been developed jointly with the consumer during the development of the PCP. When "first response" is done in a timely manner, it is anticipated that there will be fewer after-hours requests by the consumer for help.
20	First Responder	What are the requirements for after-hours first response?	The provider's policy must specify that a consumer must be able to reach a person, by phone, who has knowledge of the consumer's PCP and crisis plan. If the provider agency contracts for after-hours first responders, the contract must specify how individuals providing first response will have knowledge of the consumer's PCP and crisis plan. If consumer's concerns require immediate face-to-face contact, there must be someone from the provider agency on call to see the

Number	Service Definition Component	Question	Response
			consumer face-to-face within 2 hours.
21	First Responder	What is the relationship between first responder responsibilities and crisis/emergency services that are available within the LME service area?	If the first responder has exhausted all of the clinically appropriate options in the proactive and reactive components in the consumer's PCP crisis plan and there are immediate unresolved health and safety concerns, the first responder should contact the crisis service for assistance in implementing additional professional help (e.g. involuntary commitment, detoxification, emergency medical care, law enforcement involvement). The first responder should be contacted by a crisis service if a consumer seeks help first from the crisis service. If this occurs, the first responder should assist the crisis service in resolving the crisis.